Process: Check the clinical record. Consult with the nurse assistant and the resident. Be sure to ask about any items that are hidden from view because they are worn under clothing (e.g., pads or briefs).

Coding: Check all that apply. These items should be coded if a resident has, or has had any of the items during the 14-day observation period. Items that were in use during the observation period but were discontinued should be included. For example, if the resident had an indwelling catheter at the beginning of the observation period and it was later discontinued, the indwelling catheter would be coded. If none of the items apply, check *NONE OF ABOVE*.

Clarifications:

- There are 3 key ideas captured in Item H3a: 1) scheduled, 2) toileting, and 3) program. The word "scheduled" refers to performing the activity according to a specific, routine time that has been clearly communicated to the resident (as appropriate) and caregivers. The concept of "toileting" refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle (i.e., urinal, bedpan). Changing wet garments is not included in this concept. A "program" refers to a specific approach that is organized, planned, documented, monitored and evaluated. A scheduled toileting program could include taking the resident to the toilet, providing a bedpan at scheduled times, or verbally prompting to void.

  If the scheduled plan is recorded in the care plan and staff are actually toileting the resident according to the multiple specified times, check Item H3a. If the resident also experiences breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing if the resident has a new, reversible condition causing a decline in continence (e.g., UTI, mobility problem, etc.), and treating the underlying cause. Also determine whether or not there is a pattern to the extra times the resident is incontinent and consider adjusting the scheduled toileting plan accordingly.

  For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. If the care plan is the resource used by staff to be made aware of resident's specific toileting schedules, then the toileting schedule should appear there. Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day. If the timing of such routines is not fairly standardized, specific times should then be noted. Documentation in the clinical record should evaluate the resident's response to the toileting program.

  Feeding tubes/gastrostomies are coded in Sections K and P. Only appliances used for elimination are coded here.

H4. Change in Urinary Continence (90 days ago)

Intent: To document changes in the resident's urinary continence status as compared to 90 days ago (or since the last OBRA assessment if less than 90 days ago), including any changes in self-control categories, appliances, or programs. This item asks for a snapshot of "today" as compared to that of 90 days ago (i.e., a comparison of 2 points in time). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process: Review the resident's clinical record and Bladder Continence patterns as recorded in the last assessment (if available). Validate findings with the resident and direct care staff on all shifts. For new residents, consult with the primary family caregiver.

Coding: Code "**0**" for No change, "**1**" for Improvement, or "**2**" for Deteriorated. A resident who was incontinent 90 days ago who is now continent by virtue of a catheter should be coded as "1", Improved. A resident who was continent 90 days ago is on a bladder retraining program, but is leaking urine during the new observation period would be coded deteriorated (2).

Examples of Change in Urinary Continence

During an outbreak of gastroenteritis at the nursing facility six weeks ago, Mrs. L, who is usually continent, became totally incontinent of bladder and bowel. This problem lasted only two weeks and she has been continent for the last month. **Code "0" for No change.**

Dr. R had prostate surgery three months ago. Prior to surgery, he was frequently incontinent. Upon returning from the hospital, his indwelling catheter was discontinued. Although he initially experienced incontinence, he now remains dry with only occasional incontinence. He sings the praises of surgery to his peers. **Code "1" for Improved.**

Mrs. B is a new admission. Both she and her daughter report that she has never been incontinent of urine. By her third day of residency, her urinary incontinence became evident, especially at night. **Code "2" for Deteriorated.**

Two weeks ago Mr. K returned from the hospital following plastic surgery for a pressure ulcer. Prior to hospital admission, Mr. K was totally incontinent of urine. He is now continent with an indwelling catheter in place. **Code "1" for Improved.** ***Rationale:*** Although one could perceive that Mr. K had "deteriorated" because he now has a catheter for bladder control, remember that the MDS definition for bladder continence states "Control of bladder function with appliances (e.g., foley) or continence programs, if employed."

SECTION I.
DISEASE DIAGNOSES

Intent: To code those diseases or infections which have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. In general, these are conditions that drive the current care plan.

- The disease conditions in this section **require a physician-documented diagnosis in the clinical record**. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis.

- **Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan**. In many facilities, clinical staff and physicians neglect to update the list of resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's plan of care. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.

Definition: **Nursing Monitoring** - Includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

I1. Diseases (7-day look back)

Definition: **ENDOCRINE/METABOLIC/NUTRITIONAL**

a. Diabetes Mellitus - Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

b. Hyperthyroidism

c. Hypothyroidism

HEART/CIRCULATION

d. Arteriosclerotic Heart Disease (ASHD)

e. Cardiac Dysrhythmias - Disorder of heart rate or heart rhythm.

f. Congestive Heart Failure

g. Deep Vein Thrombosis

h. Hypertension

i. Hypotension

j. Peripheral Vascular Disease - Vascular disease of the lower extremities that can be of venous and/or arterial origin.

k. Other cardiovascular disease

MUSCULOSKELETAL

l. Arthritis - Includes degenerative joint disease (DJD), osteoarthritis (OA), and rheumatoid arthritis (RA). Record more specific forms of arthritis (e.g., Sjogren's syndrome; gouty arthritis) in Item I3 (with ICD-9-CM code).

m. Hip Fracture - Includes any hip fracture that occurred at any time that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, and subcapital fractures.

n. Missing Limb (e.g., Amputation) - Includes loss of any part of any upper or lower extremity. Missing digits should be coded in I3.

o. Osteoporosis

p. Pathological Bone Fracture - Fracture of any bone due to weakening of the bone, usually as a result of a cancerous process.

NEUROLOGICAL

q. Alzheimer's Disease

r. Aphasia - A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language.

s. Cerebral Palsy - Paralysis related to developmental brain defects or birth trauma. Includes spastic quadraplegia secondary to cerebral palsy.

t. Cerebrovascular Accident (CVA/Stroke) - A vascular insult to the brain that may be caused by intracranial bleeding, cerebral thromboses, infarcts, and emboli.

u. Dementia Other Than Alzheimer's - Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurologic

diseases other than Alzheimer's (e.g., Picks, Creutzfeld-Jacob, Huntington's disease, etc.).

v. **Hemiplegia/Hemiparesis** - Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor.

w. **Multiple Sclerosis** – Chronic disease affecting the central nervous system with remissions and relapses of weakness, incoordination, paresthesis, speech disturbances and visual disturbances.

x. **Paraplegia** - Paralysis (temporary or permanent impairment of sensation, function, motion) of the lower part of the body, including both legs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.

y. **Parkinson's Disease**

z. **Quadriplegia** - Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. (Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia.)

aa. **Seizure Disorder**

bb. **Transient Ischemia Attack (TIA)** - A sudden, temporary, inadequate supply of blood to a localized area of the brain. Often recurrent.

cc. **Traumatic Brain Injury** - Damage to the brain as a result of physical injury to the head.

PSYCHIATRIC/MOOD

dd. **Anxiety Disorder**

ee. **Depression**

ff. **Manic Depressive (Bipolar Disease)** - Includes documentation of clinical diagnoses of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic-depressive illness.

gg. **Schizophrenia**

PULMONARY

hh. Asthma

ii. Emphysema/COPD - Includes COPD (chronic obstructive pulmonary disease) or COLD (chronic obstructive lung disease), and chronic restrictive lung diseases such as asbestosis and chronic bronchitis.

SENSORY

jj. Cataracts

kk. Diabetic Retinopathy

ll. Glaucoma

mm. Macular Degeneration

OTHER

nn. Allergies - Any hypersensitivity caused by exposure to a particular allergen. Includes agents (natural and artificial) to which the resident is susceptible for an allergic reaction, not only those to which he or she currently reacted to in the last seven days. This item includes allergies to drugs (e.g., aspirin, antibiotics), foods (e.g., eggs, wheat, strawberries, shellfish, milk), environmental substances (e.g., dust, pollen), animals (e.g., dogs, birds, cats), and cleaning products (e.g., soap, laundry detergent), etc. Hypersensitivity reactions include but are not limited to, itchy eyes, runny nose, sneezing, contact dermatitis, etc.

oo. Anemia - Includes anemia of any etiology.

pp. Cancer

qq. Renal Failure

rr. ***NONE OF ABOVE (Not Used on the MPAF)***

Process: Consult transfer documentation and medical record (including current physician treatment orders and nursing care plans). If the resident was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD-9-CM codes that were current during the hospital stay. If these diagnoses are still active, record them on the MDS form. Also, accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation of current diagnoses in the clinical record.

Check a disease item only if the disease has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, it is not necessary to check "hypertension" if one episode occurred several years ago unless the hypertension is either currently being controlled with medications, diet, biofeedback, etc., or is being regularly monitored to prevent a recurrence.

Physician involvement in this part of the assessment process is crucial. The physician should be asked to review the items in Section I, close to the scheduled MDS. Use this scheduled visit as an opportunity to ensure that active diagnoses are noted and "inactive" diagnoses are designated as resolved. This is also an important opportunity to share the entire MDS assessment with the physician. In many nursing facilities physicians are not brought into the MDS review and assessment process. It is the responsibility of facility staff to aggressively solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, you should share this section of the MDS with the physician and ask for his or her input. Physicians completing a portion of the MDS assessment should sign in Item R2 (Signatures of Those Completing the Assessment).

Full physician review of the most recent MDS assessment or ongoing input into the assessment currently being completed can be very useful. For the physician, the MDS assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional follow-up.

Coding: Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE (Not Used on the MPAF)*. If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I1, check the more general diagnosis in I1 and then enter the more detailed diagnosis (with ICD-9-CM code) under I3. Coders in long-term care facilities should refer to official coding guidance in assigning and reporting code numbers.

For example: If the record reveals that the resident has "osteoarthritis" you check Item I1l (Arthritis) and record "Osteoarthritis" with 1CD-9-CM Code 715.00 in Section I3.

Consult the resident's transfer documentation (in the case of new admissions or re-admissions) and current medical record including current nursing care plans. There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, as indicated above, accept statements by the

resident that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

For example: If a new resident says he or she had a severe depression and was seeing a private psychiatrist in the community, this information may have been missed if the information was not carried forward in records accompanying the resident from an acute care hospital to the nursing facility.

The following chart of ICD-9-CM codes for diseases listed in Item I1 is intended to clarify the level of specificity represented when the disease item is checked. This is also the list to use in computer applications of the MDS.

Clarifications:

- Residents with communication problems as a result of Alzheimer's, Parkinson's or multi-infarct dementia need to be carefully assessed. These diagnoses may result in impairment in the ability to comprehend or express language that may affect some or all channels of communication, including listening, reading, speaking, writing and gesturing.

- Depression secondary to Alzheimer's disease should be coded only if there is physician documentation in clinical record to support the diagnoses.

  If the resident with a diagnosis of Alzheimer's disease has expressions/features defined in Section E, Mood and Behavior Patterns, code accordingly. The resident's diagnosis of depression should have physician's documentation supporting the diagnosis. In addition, staff should address the resident's mood and behavior in the resident's record.

  In situations such as this, always ask the resident's physician to provide clarification to assure proper coding of the disease or condition.

ICD-9-CM Codes for Diseases Listed in Section I1

ICD-9-CM Code	Disease Condition
ENDOCRINE/METABOLIC/NUTRITIONAL	
250.00	Diabetes mellitus
242.9[0 or1]	Hyperthyroidism
244.9	Hypothyroidism
HEART/CIRCULATION	
414.00 through 414.03	Arteriosclerotic heart disease (ASHD)
427.9	Cardiac dysrhythmia
428.0	Congestive heart failure
453.8	Deep vein thrombosis
401.9	Hypertension (unspecified)
458.9	Hypotension (unspecified)
443.9	Peripheral vascular disease (unspecified)
429.2	Other cardiovascular disease
MUSCULOSKELETAL	
716.90	Arthritis (unspecified site)
820.9	Hip fracture (unspecified site or NOS [not otherwise specified])
736.89	Missing limb (e.g., amputation)
733.00	Osteoporosis (unspecified)
733.10	Pathological bone fracture (unspecified sites)

(continued on next page)

ICD-9-CM Codes for Diseases Listed in Section I1 (continued)

ICD-9-CM Code	Disease Condition
NEUROLOGICAL	
331.0	Alzheimer's disease
784.3	Aphasia
343.00 through 343.90	Cerebral palsy (unspecified)
436	Cerebrovascular accident (stroke) (NOS acute)
290.0	Dementia other than Alzheimer's (Senile Dementia, NOS)
342.90 through 342.92	Hemiplegia/Hemiparesis
340	Multiple sclerosis (NOS)
344.1	Paraplegia
332.0	Parkinson's disease
344.00 through 344.09	Quadriplegia
780.3	Seizure disorder
435.9	Transient ischemic attack (TIA) (unspecified)
854.00	Traumatic brain injury (unspecified)
PSYCHIATRIC/MOOD	
300.00	Anxiety disorder (unspecified)
311	Depression
296.8	Manic depression (bipolar disease)
295.90	Schizophrenia (unspecified)
PULMONARY	
493.90	Asthma (unspecified)
492.8	Emphysema
496	COPD
SENSORY	
366.9	Cataracts (unspecified)
362.01, 362.02 and 250.50 through 250.53	Diabetic retinopathy
365.9	Glaucoma (unspecified)
362.50	Macular degeneration (unspecified)
OTHER	
995.3	Allergies (unspecified)
285.9	Anemia
199.1	Cancer (unspecified as to site or stage)
586	Renal failure (unspecified)

ICD-9-CM: The International Classification of Diseases – 9th Revision - Clinical Modification. Ann Arbor, Michigan: Edward Brothers, Inc., October 1989.

I2. Infections (7-day look back)

Definition:

a. Antibiotic Resistant Infection (e.g., including but not limited to Methicillin Resistant Staphylococcus Aureus (MSRA), Methycillin Amnioglycocite Resistant Staphylococcus Aureus, and Vancomycin Resistant Enterococcus (VRE), and Extended Spectrum Beta-Lactalase Organisms) - An infection in which bacteria have developed a resistance to the effective actions of an antibiotic. Check this item only if there is supporting documentation in the clinical record (including transmittal records of new admissions and recent transfers from other institutions).

b. Clostridium Difficile (C.diff) - Diarrheal infection caused by the Clostridium difficile bacteria. Check this item only if there is supporting documentation in the clinical record of new admissions and recent transfers (e.g., hospital referral or discharge summary, laboratory report).

c. Conjunctivitis - Inflammation of the mucous membranes lining the eyelids. May be of bacterial, viral, allergic, or traumatic origin.

d. HIV Infection - Check this item only if there is supporting documentation or the resident (or surrogate decision-maker) informs you of the presence of a positive blood test result for the Human Immunodeficiency Virus or diagnosis of AIDS. If a state has a policy to omit transmission of HIV information, the State policy supercedes the MDS requirement.

e. Pneumonia - Inflammation of the lungs; most commonly of bacterial or viral origin.

f. Respiratory Infection - Any upper or lower (e.g., bronchitis) respiratory infection other than pneumonia.

g. Septicemia - Morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted, provided the physician has documented the septicemia diagnosis in the resident's clinical record.

h. Sexually Transmitted Diseases - Check this item only if there is supporting documentation of a current diagnosis including but not limited to gonorrhea, or syphilis. DO NOT include HIV in this category. If a state has established statutory or regulatory privacy policies precluding transmission of sexually transmitted diseases information, the State policy supercedes the MDS requirement.

i. Tuberculosis - Includes residents with active tuberculosis or those who have converted to PPD positive tuberculin status and are currently receiving drug treatment (e.g., isoniazid (INH), ethambutol, rifampin, cycloserine) for tuberculosis.

j. Urinary Tract Infection - Includes chronic and acute symptomatic infection(s) in the last 30 days. Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record. For a new UTI condition identified during the observation period, a physician's working diagnosis of UTI provides sufficient documentation to code the UTI at Item I2j, as long as the urine culture has been done and you are waiting for results. The diagnosis of UTI, along with lab results when available, must be documented in the resident's clinical record. However, if it is later determined that the UTI was not present, staff should complete a correction to remove the diagnosis from the MDS record.

In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:

A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results**. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

k. Viral Hepatitis - Inflammation of the liver of viral origin. This category includes diagnoses of hepatitis A, hepatitis B, hepatitis non-A non-B, hepatitis C, and hepatitis E.

l. Wound infection - Infection of any type of wound (e.g., surgical; traumatic; pressure) on any part of the body.

m. ***NONE OF ABOVE***

Process: Consult transfer documentation and the resident's clinical record (including current physician treatment orders and nursing care plans). Accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation.

Physician involvement in this part of the assessment process is crucial.

Coding: Check an item only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death. Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan. For example, do not check "tuberculosis" if the resident had TB several years ago

unless the TB is either currently being controlled with medications or is being regularly monitored to detect a recurrence.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE*. If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I2 check the appropriate box in I2 and enter the more detailed information (with ICD-9-CM code) under I3.

ICD-9-CM Codes for Diseases Listed in Section I2

ICD-9-CM Code	Disease Condition
INFECTION	
041.9, 041.11, 041.19	Antibiotic resistant infection (e.g., methicillin resistant staph)
040.0	Clostridium difficile (C.diff)
372.30	Conjunctivitis
042	HIV infection
486	Pneumonia (organism unspecified)
038.9	Septicemia (not otherwise specified)
099.9	Sexually transmitted diseases (Venereal diseases) (unspecified)
011.90	Tuberculosis (pulmonary unspecified)
599.0	Urinary tract infection (site not specified)
070.9	Viral hepatitis (unspecified, without mention of hepatic coma)
958.3, 998.5	Wound infection

ICD-9-CM: The International Classification of Diseases - 9th Revision - Clinical Modification. Ann Arbor, Michigan: Edward Brothers, Inc., October 1989.

I3. Other Current Diagnoses and ICD-9-CM Codes (7-day look back)

Intent: To identify conditions not listed in Item I1 and I2 that affect the resident's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, or risk of death. Also, to record more specific designations for general disease categories listed under I1 and I2.

Coding: Enter the description of the diagnoses on the lines provided. For each diagnosis, an ICD-9-CM code must be entered in the boxes to the right of the line. If this information is not available in the medical records, consult the most recent version of the full set of volumes of ICD-9-CM codes. V codes may be used if they affect the resident's current ADL status, mood and behavior status, medical treatments, nursing monitoring, or risk of death.

SECTION J.
HEALTH CONDITIONS

J1. Problem Conditions (7-day look back)

To record specific problems or symptoms that affect or could affect the resident's health or functional status, and to identify risk factors for illness, accident, and functional decline.

INDICATORS OF FLUID STATUS

Definition:

a. **Weight Gain or Loss of 3 or More Pounds Within a 7-Day Period** - This can only be determined in residents who are weighed in the same manner at least weekly. However, the majority of residents will not require weekly or more frequent weighings, and for these residents you will be unable to determine if there has been a 3 or more pound gain or loss. When this is the case, leave this item blank.

b. **Inability to Lie Flat Due to Shortness of Breath** - Resident is uncomfortable lying supine. Resident requires more than one pillow or having the head of the bed mechanically raised in order to get enough air (orthopnea). This symptom often occurs with fluid overload. If the resident has shortness of breath when not lying flat, also check Item J1l, "Shortness of breath." If the resident does not have shortness of breath when upright (e.g., O.K. when using two pillows or sitting up), do not check Item J1l.

c. **Dehydrated; Output Exceeds Intake** - Check this item if the resident has 2 or more of the following indicators.

- Resident usually takes in less than the recommended 1500 ml of fluids daily (water or liquids in beverages, and water in high fluid content foods such as gelatin and soups). Note: The recommended intake level has been changed from 2500 ml to 1500 ml to reflect current practice standards.

- Resident has clinical signs of dehydration, such as dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium albumin, blood urea nitrogen, or urine specific gravity).

- Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).

d. Insufficient Fluid; Did NOT Consume All/Almost All Liquids Provided During Last 3 Days - Liquids can include water, juices, coffee, gelatins, and soups. This item should be coded only when the resident is receiving, but not consuming, the proper amount of fluids to meet their daily minimum or assessed requirements. The item should not be coded for residents who may request excessive amounts above and beyond what could reasonably be expected to be consumed.

OTHER

e. Delusions - Fixed, false beliefs not shared by others that the resident holds even when there is obvious proof or evidence to the contrary (e.g., belief he or she is terminally ill; belief that spouse is having an affair; belief that food served by the facility is poisoned).

f. Dizziness/Vertigo - The resident experiences the sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

g. Edema - Excessive accumulation of fluid in tissues, either localized or systemic (generalized). Includes all types of edema (e.g., dependent, pulmonary, pitting).

h. Fever – A fever is present when the resident's temperature (°F) is 2.4 degrees greater than the baseline temperature. The baseline temperature may have been established prior to the Assessment Reference Date.

i. Hallucinations - False perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes).

j. Internal Bleeding - Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds," hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled should not be coded as internal bleeding.

k. Recurrent Lung Aspirations in Last 90 Days - Note the extended time frame. Often occurs in residents with swallowing difficulties or who receive tube feedings (i.e., esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be X-ray evidence of lung aspiration for this item to be checked.

l. Shortness of Breath - Difficulty breathing (dyspnea) occurring at rest, with activity, or in response to illness or anxiety. If the resident has shortness of breath while lying flat, also check Item J1b ("Inability to lie flat due to shortness of breath.").

m. Syncope (Fainting) - Transient loss of consciousness, characterized by unresponsiveness and loss of postural tone with spontaneous recovery.

n. Unsteady Gait - A gait that places the resident at risk of falling. Unsteady gaits take many forms. The resident may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits may include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

o. Vomiting - Regurgitation of stomach contents; may be caused by any etiology (e.g., drug toxicity; influenza; psychogenic).

p. ***NONE OF ABOVE (Not Used on the MPAF)***

Process: It is often difficult to recognize when a frail, chronically ill elder is experiencing dehydration or, alternatively, fluid overload that could precipitate congestive heart failure. Ways to monitor the problem, particularly in residents who are unable to recognize or report the common symptoms of fluid variation, are as follows: Ask the resident if he or she has experienced any of the listed symptoms in the last seven days. Review the clinical records (including current nursing care plan) and consult with facility staff members and the resident's family if the resident is unable to respond. A resident may not complain to staff members or others, attributing such symptoms to "old age." Therefore, it is important to ask and observe the resident, directly if possible, since the health problems being experienced by the resident can often be remedied.

Coding: Check all conditions that occurred within the past seven days unless otherwise indicated (i.e. lung aspirations in the last 90 days). If no conditions apply, check *NONE OF ABOVE (Not Used on the MPAF)*.

J2. Pain Symptoms (7-day look back)

Intent: To record the **frequency** and **intensity** of signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions.

MDS 2.0 only captures pain symptoms. Documentation of pain management/interventions are recorded elsewhere in the resident's clinical record, such as in the nurses' notes, progress notes, medication records, and care plans.

CMS anticipates that few residents on pain management measures will not have some level of breakthrough pain during the 7-Day assessment period that should then be coded on the MDS. For example, if through assessment or clinical record review you note that the resident has received pain medications or other pain relief measures, investigate the pain need and capture the pain event on the MDS. However, if the resident does not experience ANY breakthrough pain in the 7-Day assessment window, the assessor would indeed code "0", no pain. Remember that the assessment covers a 7-day period and should reflect the highest level of pain reported by any staff member, not just the assessment of the professional completing the MDS.

Definition: **Pain** - For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

Shows Evidence of Pain - Depends on the observation of others (i.e., cues), either because the resident does not verbally complain, or is unable to verbalize.

Process: Ask the resident if he or she has experienced any pain in the last seven days. Ask him/her to describe the pain. If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, but rather may be indicative of multiple problems, code for the frequency and intensity of symptoms if in your clinical judgment it is possible that the behavior could be caused by the resident experiencing pain.

Ask nurse assistants and therapists who work with the resident if the resident had complaints or indicators of pain in the last week.

Coding: Code for the highest level of pain present in the last seven days. Code for the presence or absence of pain, regardless of pain management efforts; i.e., breakthrough pain. If the resident has no pain, code "0" (No Pain) then Skip to Item J4. If the resident does not experience any breakthrough pain, or the resident's goal for pain management is being met in the 7-day assessment

window, this item must also be coded "0". Remember that the assessment covers a 7-day period and should reflect the highest level of pain present.

a. FREQUENCY - How often the resident complains or shows evidence of pain.

Codes:
0. No pain (Skip to Item J4)
1. Pain less than daily
2. Pain daily

b. INTENSITY - The severity of pain as described or manifested by the resident.

Codes:
1. Mild Pain - Although the resident experiences some ("a little") pain he or she is usually able to carry on with daily routines, socialization, or sleep.

2. Moderate Pain - Resident experiences "a medium" amount of pain.

3. Times When Pain is Horrible or Excruciating - Worst possible pain. Pain of this type usually interferes with daily routines, socialization and sleep.

Facilities should have a consistent, uniform and standardized process to measure and assess pain. Use your best clinical judgment when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain. ***Rationale*:** Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain. Pain control often enables rehabilitation, greater socialization and activity involvement. The 5 coding examples shown below were designed to assist you in making appropriate coding decisions. Please note that the last 3 examples are new, and did not appear in the original MDS manual.

Examples	Pain Frequency	Pain Intensity
Mrs. G, a resident with poor short-and-long-term memory and moderately impaired cognitive function asked the charge nurse for "a pill to make my aches and pains go away" once a day during the last 7 days. The medication record shows that she received Tylenol every evening. The charge nurse states that Mrs. G usually rubs her left hip when she asks for a pill. However, when you ask her about pain, Mrs. G tells you that she is fine and never has pain. ***Rationale for coding*:** It appears that Mrs. G has forgotten that she has reported having pain during the last 7 days. Best clinical judgment calls for coding that reflects that Mrs. G has mild, daily pain.	2	1
Mr. T is cognitively intact. He is up and about and involved in self-care, social and recreational activities. During the last week he has been cheerful, engaging and active. When checked by staff at night, he appears to be sleeping. However, when you ask him how he's doing, he tells you that he has been having horrible cramps in his legs every night. He's only been resting, but feels tired upon arising. ***Rationale for coding*:** Although Mr. T may look comfortable to staff, he reports to you that he has terrible cramps. Best clinical judgment for coding this "screening" item for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants a further evaluation.	2	3
Mr. C is cognitively intact. He has long-term degenerative joint disease and his pain is well managed on Celebrex daily. He stated that on most days he feels little to no pain. However, Mr. C was unable to ambulate for long distances on two days last week, as he was experiencing moderate pain in his knees. Mr. C stated that he needed additional assistance from the CNA to walk to the dining room on those days and required additional pain medication. He says that he no longer feels that intensity of pain.	1	2

Examples (continued)	Pain Frequency	Pain Intensity
Mrs. S is severely cognitively impaired. She is unable to make decisions and requires extensive assistance in daily ADL care. The CNA responsible for her care and daily ambulation reports to the charge nurse that she has noticed Mrs. C to have "pain in her back" when the CNA attempts to position her in bed and transfer her to a chair. The nurse observes Mrs. C's physical, facial and verbal expressions during care and determines that the resident is experiencing moderate pain. The physician is notified and orders Tylenol q 6 hours. The resident appears relieved later in the day. The resident is observed by nursing staff and they determine that she is no longer experiencing a moderate level of pain. The physician determines that the resident should continue on the medication for several days.	1	2
Mr. W had abdominal surgery 5 days ago. He is alert with short-term memory problems. He is on pain medication daily and is able to participate in daily activities. On the evening shift, Mr. W complained to the nurse that he was experiencing severe pain near his wound site. Upon examination, the nurse determined that the wound appeared clean with no signs of infection. The physician was notified and determined that Mr. W required a change in the type of medication. Mr. W reported relief and remained on the new medication for 3 additional days.	1	3

J3. Pain Site (7-day look back)

Intent: To record the location of physical pain as described by the resident, or discerned from objective physical and laboratory tests. Sometimes it is difficult to pinpoint the exact site of pain, particularly if the resident is unable to describe the quality and location of pain in detail. Likewise, it will be difficult to pinpoint the exact site if the resident has not had physical or laboratory tests to evaluate the pain. In order to begin to develop a responsive care plan for promoting comfort, the intent of this item is to help residents and caregivers begin a pain evaluation by attempting to target the site of pain.

Definition: **a. Back Pain** - Localized or generalized pain in any part of the neck or back.

b. Bone Pain - Commonly occurs in metastatic disease. Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.

c. Chest Pain While Doing Usual Activities - The resident experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc. "Usual activities" are those that the resident engages in normally. For example, the resident's usual activities may be limited to minor participation in dressing and grooming, short walks from chair to toilet room.

d. Headache - The resident regularly complains or shows evidence (clutching or rubbing the head) of headache.

e. Hip Pain - Pain localized to the hip area. May occur at rest or with physical movement.

f. Incisional Pain - The resident complains or shows evidence of pain at the site of a recent surgical incision.

g. Joint Pain (Other Than Hip) - The resident complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.

h. Soft Tissue Pain - Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, and wound pain.

i. Stomach Pain - The resident complains or shows evidence of pain or discomfort in the left upper quadrant of the abdomen.

j. Other - Includes either localized or diffuse pain of any other part of the body. Examples include general "aches and pains," etc.

Process: Ask the resident and observe for signs of pain. Consult staff members. Review the clinical record. Use your best clinical judgment.

Coding: Check all that apply during the last 7 days. If the resident has mouth pain check Item K1c in Section K, "Oral/Nutritional Status."

J4. Accidents (30 and 180 day look backs)

Intent: To determine the resident's risk of future falls or injuries. Falls are a common cause of morbidity and mortality among elderly nursing facility residents. Residents who have sustained at least one fall are at risk of future falls.

Definition: **a. Fell in past 30 Days**

b. Fell in Past 31-180 Days

c. Hip Fracture (from any cause) in Last 180 Days - Note time frame (last 180 days).

d. Other Fracture (from any cause) in Last 180 Days - Any fracture other than a hip fracture. Note time frame (last 180 days).

e. ***NONE OF ABOVE***

Process: **New Admissions** - Consult with the resident and the resident's family. Review transfer documentation.

Current Residents - Review the resident's records (including incident reports, current nursing care plan, and monthly summaries). Consult with the resident. Sometimes, a resident will fall, and believing that he or she "just tripped," will get up and not report the event to anyone. Therefore, do not rely solely on the clinical records but also ask the resident directly if he or she has fallen during the indicated time frame.

Coding: Check all conditions that apply. If no conditions apply, check *NONE OF ABOVE*.

Clarification:

- Current CMS policy regarding falls includes:

  a) An episode where a resident lost his/her balance and would have fallen, were it not for staff intervention, is a fall. In other words, an intercepted fall is still a fall.

  b) The presence or absence of a resultant injury is not a factor in the definition of a fall. A fall without injury is still a fall.

  c) When a resident is found on the floor, the facility is obligated to investigate and try to determine how he/she got there, and to put into place an intervention to prevent this from happening again. Unless there is evidence suggesting otherwise, the most logical conclusion is that a fall has occurred.

  d) The distance to the next lower surface (in this case, the floor) is not a factor in determining whether or not a fall occurred. If a resident rolled off a bed or mattress that was close to the floor, this is a fall.

  The point of accurately capturing occurrences of falls on the assessment is to identify and communicate resident problems/potential problems, so that staff will consider and implement interventions to prevent falls and injuries from falls. In the instance of a resident rolling off a mattress that is close to the floor - even though this is still recorded as a fall, it might

be true that staff have already assessed and intervened, and that placing a bed close to the floor to avoid injuries from falls is the intervention that best suits this individual resident.

J5. Stability of Conditions (7-day look back)

Intent: To determine if the resident's disease or health conditions present over the last seven days are acute, unstable, or deteriorating.

Definition:

a. Conditions/Diseases Make Resident's Cognitive, ADL, Mood or Behavior Patterns Unstable (Fluctuating, Precarious, or Deteriorating) - Denotes the changing and variable nature of the resident's condition. For example, a resident may experience a variable response to the intensity of pain and the analgesic effect of pain medications. On "good days" over the last seven days, he or she will participate in ADLs, be in a good mood, and enjoy preferred leisure activities. On "bad days," he or she will be dependent on others for care, be agitated, cry, etc. Likewise, this category reflects the degree of difficulty in achieving a balance between treatments for multiple conditions.

b. Resident Experiencing an Acute Episode or a Flare-Up of a Recurrent or Chronic Problem - Resident is symptomatic for an acute health condition (e.g., new myocardial infarction; adverse drug reaction; influenza), a recurrent (acute) condition (e.g., aspiration pneumonia; urinary tract infection) or an acute phase of a chronic disease (e.g., shortness of breath, edema, and confusion in a resident with congestive heart disease; acute joint pain and swelling in a resident who has had arthritis for many years). An acute episode is usually of sudden onset, has a time-limited course, and requires physician evaluation and a significant increase in licensed nursing monitoring.

c. End-Stage Disease, 6 or Fewer Months to Live - In one's best clinical judgment, the resident with any end-stage disease has only 6 or fewer months to live. This judgment should be substantiated by a well documented disease diagnosis and deteriorating clinical course. A doctor's certification that the resident has six months or less to live must be present in the record before coding the resident as terminal on the MDS.

d. *NONE OF ABOVE*

Process: Observe the resident. Consult staff members, especially the resident's physician. Review the resident's clinical record.

Coding: Check all that apply during last seven days. If none apply, check *NONE OF ABOVE.*

Examples

Mrs. M is diabetic. She requires daily or more frequent blood sugar tests in conjunction with administering sliding-scale insulin dosages. She has been confused on one occasion in the past week when she was hypoglycemic. **Check "a" for unstable - fluctuating, precarious, or deteriorating.**

If Mrs. M (above) were also to have pneumonia and fever during her assessment period, **check "a" for unstable and "b" for acute**.

Ms. F had been doing well and was ready for discharge to her apartment in elderly housing until she came down with the flu. Currently she has a low-grade fever, general aches and pains, and respiratory symptoms of productive cough and nasal congestion. Although she has taken to bed for a few days she has had no change in ADL function, mood, etc. and is looking forward to discharge in a few days. **Check "b" for acute.**

Mrs. T was admitted to the unit with a diagnosis of chronic congestive heart failure. During the past few months she has had 3 hospital admissions for acute CHF. Her heart has become significantly weaker despite maximum treatment with medications and oxygen. Her physician has discussed her deteriorating condition with her and her family and has documented that her prognosis for survival beyond the next couple of months is poor. **Check "c" for end-stage disease.**

Mr. R is a diabetic who receives a daily dose of NPH insulin 20 units sc QAM. He requires only monthly blood sugar determinations for follow-up, and has no current acute illness. **Check "d" for *NONE OF ABOVE*.**

SECTION K.
ORAL/NUTRITIONAL STATUS

Residents in nursing facilities challenge the staff with many conditions that could affect their ability to consume food and fluids to maintain adequate nutrition and hydration. Early problem recognition can help to ensure appropriate and timely nutritional intervention. Prevention is the goal, and early detection and modification of interventions is the key. Section K, Oral and Nutritional Status, should assist the nursing facility staff in recognizing nutritional deficits that will need to be addressed in a resident's care plan. Nurse assessors will need to collaborate with the dietitian and dietary staff to ensure that some items in this section have been assessed and calculated accurately.

Keep in mind that Section 1.13 states that the RAI must be conducted or coordinated with the appropriate participation of health professionals…facilities have flexibility in determining who should participate in the assessment process, as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.

K1. Oral Problems (7-day look back)

Intent: To record any oral problems present in the last seven days.

Definition:

a. Chewing Problem - Inability to chew food easily and without pain or difficulties, regardless of cause (e.g., resident uses ill-fitting dentures, or has a neurologically impaired chewing mechanism, or has temporomandibular joint [TMJ] pain, or a painful tooth). Code chewing problem even when interventions have been successfully introduced.

b. Swallowing Problem - Dysphagia. Clinical manifestations include frequent choking and coughing when eating or drinking, holding food in mouth for prolonged periods of time, or excessive drooling. Code swallowing problem even when interventions have been successfully introduced.

c. Mouth Pain - Any pain or discomfort associated with any part of the mouth, regardless of cause. Clinical manifestations include favoring one side of the mouth while eating, refusing to eat, refusing food or fluids of certain temperatures (hot or cold).

d. ***NONE OF ABOVE (Not Used on the MPAF)***

Process: Ask the resident about difficulties in these areas. Observe the resident during meals. Review the medical record for staff observations about the residents; e.g.,